Transforming Lives

Skin Observation Protocol for Delegating Nurses

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EXPECTATION/OUTCOME FOR SOP

Documentation Standards

- HCS—guidelines in Chapter 24 of the HCS Long Term (LTC) Manual
- DDA—guidelines in Policy 9.13

Comprehensive Assessment Reporting and Evaluation (CARE)

Computerized client assessment

Triggers Skin Observation Protocol

Mandatory Assessment

CASE MANAGERS RESPONSIBILITY

- Identified in CARE
  - SOP triggered
  - Requires referral for SOP and include all the other triggered referrals
  - Document in CARE referral process
- Case Manager determines appropriate provider
  - Nurse Delegator
  - AAA
  - Nursing agency

NURSE DELEGATORS RESPONSIBILITY

- Accept referral—time frame (DDA-HCS)

HCS	DDA
CM SEND REFERRAL FORM IN 2 BUSINESS DAYS	CM SEND REFERRAL FORM IN 2 BUSINESS DAYS
48 HOURS RESPOND TO REFERRAL	RND HAS 1 DAY TO ACCEPT AND 2 DAYS SCHEDULE VISIT
5 DAYS RETURN DOCUMENTATION TO CASE MANAGER	5 DAYS RETURN DOCUMENTATION TO CASE MANAGER

ON SITE VISIT AND DIRECT OBSERVATION REQUIRED

RND RESPONSIBILITIES

- Review CARE and document
  - Review current treatment and who authorized plan
  - Develop a care plan or
  - Verify current treatment plan in place
  - Verify CG is checking pressure points
  - Distribute educational materials
  - Address all the other nursing triggered referrals

RND SOP RESPONSIBILITIES

- Determine if a HCP is treating clients skin issue
- Contact HCP for treatment orders if necessary
- Contact client's family rep if no HCP, if client refusing treatment or if HCP is not treating

RND SOP RESPONSIBILITIES*(cont'd)*

- Discuss findings with case manager
- Refer to APS, CPS, CRU, health care provider/resources as appropriate

RND REQUIRED DOCUMENTATION

Skin assessments are part of the nurse delegation paperwork and copies should be left in the client chart and retained in your own personal nurse delegation files. As a part of the assessment, the RND will address all the other referrals if indicated.

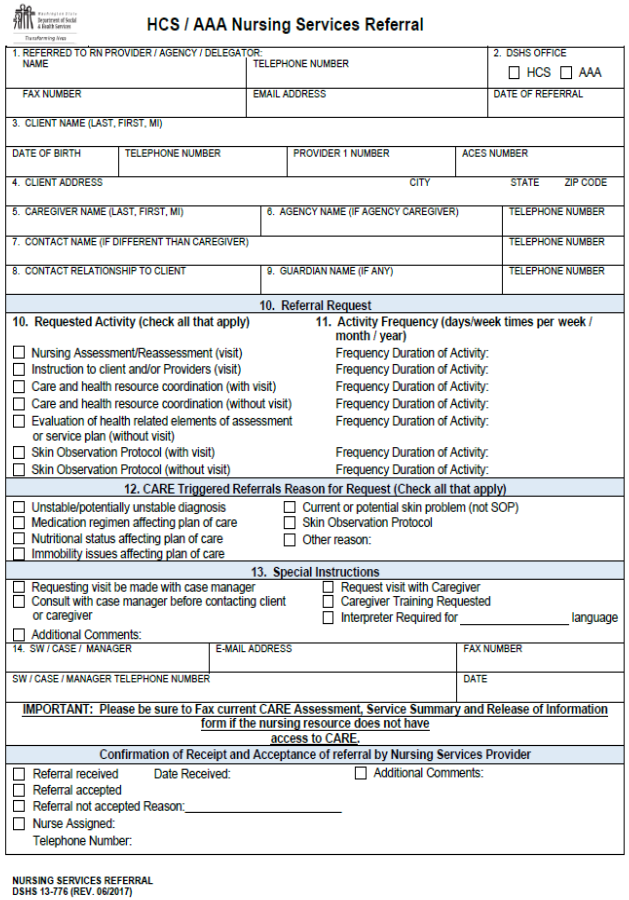
RND REQUIRED DOCUMENTATION

A copy of the documentation must be sent to the referral case manager for documentation into the CARE assessment.

MANDATORY FORMS--SOP

- HCS Referral Form # 13-776
- DDA Referral Form #13-911
- Basic Assessment Form #13-784
- Skin Assessment Form # 13-780
- Pressure Injury Assessment # 13-783

SOP REFERRAL FORM-HCS # 13-776



HCS / AAA Nursing Services Referral

1. REFERRED TO RN PROVIDER / AGENCY / DELEGATOR: NAME	TELEPHONE NUMBER	2. DSHS OFFICE ☐ HCS ☐ AAA
FAX NUMBER	EMAIL ADDRESS	DATE OF REFERRAL

3. CLIENT NAME (LAST, FIRST, MI)

DATE OF BIRTH	TELEPHONE NUMBER	PROVIDER 1 NUMBER	ACES NUMBER

4. CLIENT ADDRESS CITY STATE ZIP CODE

5. CAREGIVER NAME (LAST, FIRST, MI)	6. AGENCY NAME (IF AGENCY CAREGIVER)	TELEPHONE NUMBER
7. CONTACT NAME (IF DIFFERENT THAN CAREGIVER)		TELEPHONE NUMBER
8. CONTACT RELATIONSHIP TO CLIENT	9. GUARDIAN NAME (IF ANY)	TELEPHONE NUMBER

10. Referral Request

10. Requested Activity (check all that apply)	11. Activity Frequency (days/week times per week / month / year)
☐ Nursing Assessment/Reassessment (visit)	Frequency Duration of Activity:
☐ Instruction to client and/or Providers (visit)	Frequency Duration of Activity:
☐ Care and health resource coordination (with visit)	Frequency Duration of Activity:
☐ Care and health resource coordination (without visit)	Frequency Duration of Activity:
☐ Evaluation of health related elements of assessment or service plan (without visit)	Frequency Duration of Activity:
☐ Skin Observation Protocol (with visit)	Frequency Duration of Activity:
☐ Skin Observation Protocol (without visit)	Frequency Duration of Activity:

12. CARE Triggered Referrals Reason for Request (Check all that apply)

☐ Unstable/potentially unstable diagnosis	☐ Current or potential skin problem (not SOP)
☐ Medication regimen affecting plan of care	☐ Skin Observation Protocol
☐ Nutritional status affecting plan of care	☐ Other reason:
☐ Immobility issues affecting plan of care	

13. Special Instructions

☐ Requesting visit be made with case manager	☐ Request visit with Caregiver
☐ Consult with case manager before contacting client or caregiver	☐ Caregiver Training Requested
	☐ Interpreter Required for _____ language

☐ Additional Comments:

14. SW / CASE / MANAGER	E-MAIL ADDRESS	FAX NUMBER
SW / CASE / MANAGER TELEPHONE NUMBER		DATE

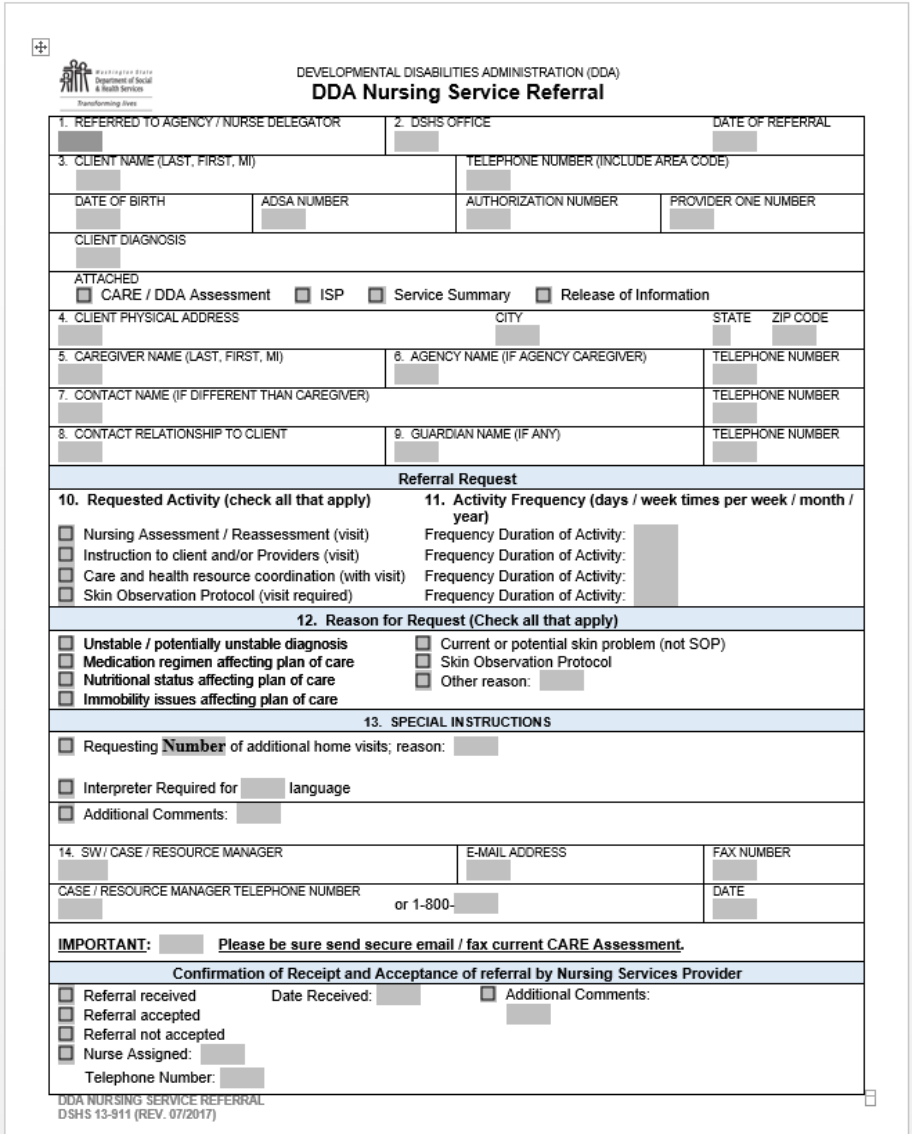
IMPORTANT: Please be sure to Fax current CARE Assessment, Service Summary and Release of Information form if the nursing resource does not have access to CARE.

Confirmation of Receipt and Acceptance of referral by Nursing Services Provider

☐ Referral received Date Received: ☐ Additional Comments:
☐ Referral accepted
☐ Referral not accepted Reason:_____
☐ Nurse Assigned:
Telephone Number:

NURSING SERVICES REFERRAL
DSHS 13-776 (REV. 06/2017)

SOP REFERRAL FORM—DDA # 13-911



DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

DDA Nursing Service Referral

1. REFERRED TO AGENCY / NURSE DELEGATOR	2. DSHS OFFICE	DATE OF REFERRAL
3. CLIENT NAME (LAST, FIRST, MI)	TELEPHONE NUMBER (INCLUDE AREA CODE)	
DATE OF BIRTH / ADSA NUMBER	AUTHORIZATION NUMBER	PROVIDER ONE NUMBER
CLIENT DIAGNOSIS		

ATTACHED
☐ CARE / DDA Assessment ☐ ISP ☐ Service Summary ☐ Release of Information

4. CLIENT PHYSICAL ADDRESS	CITY	STATE	ZIP CODE
5. CAREGIVER NAME (LAST, FIRST, MI)	6. AGENCY NAME (IF AGENCY CAREGIVER)	TELEPHONE NUMBER	
7. CONTACT NAME (IF DIFFERENT THAN CAREGIVER)		TELEPHONE NUMBER	
8. CONTACT RELATIONSHIP TO CLIENT	9. GUARDIAN NAME (IF ANY)	TELEPHONE NUMBER	

Referral Request

10. Requested Activity (check all that apply)	11. Activity Frequency (days / week times per week / month / year)
☐ Nursing Assessment / Reassessment (visit)	Frequency Duration of Activity:
☐ Instruction to client and/or Providers (visit)	Frequency Duration of Activity:
☐ Care and health resource coordination (with visit)	Frequency Duration of Activity:
☐ Skin Observation Protocol (visit required)	Frequency Duration of Activity:

12. Reason for Request (Check all that apply)

☐ **Unstable / potentially unstable diagnosis**	☐ Current or potential skin problem (not SOP)
☐ **Medication regimen affecting plan of care**	☐ Skin Observation Protocol
☐ **Nutritional status affecting plan of care**	☐ Other reason:
☐ **Immobility issues affecting plan of care**	

13. SPECIAL INSTRUCTIONS

☐ Requesting **Number** of additional home visits; reason:

☐ Interpreter Required for language

☐ Additional Comments:

14. SW / CASE / RESOURCE MANAGER	E-MAIL ADDRESS	FAX NUMBER
CASE / RESOURCE MANAGER TELEPHONE NUMBER or 1-800-		DATE

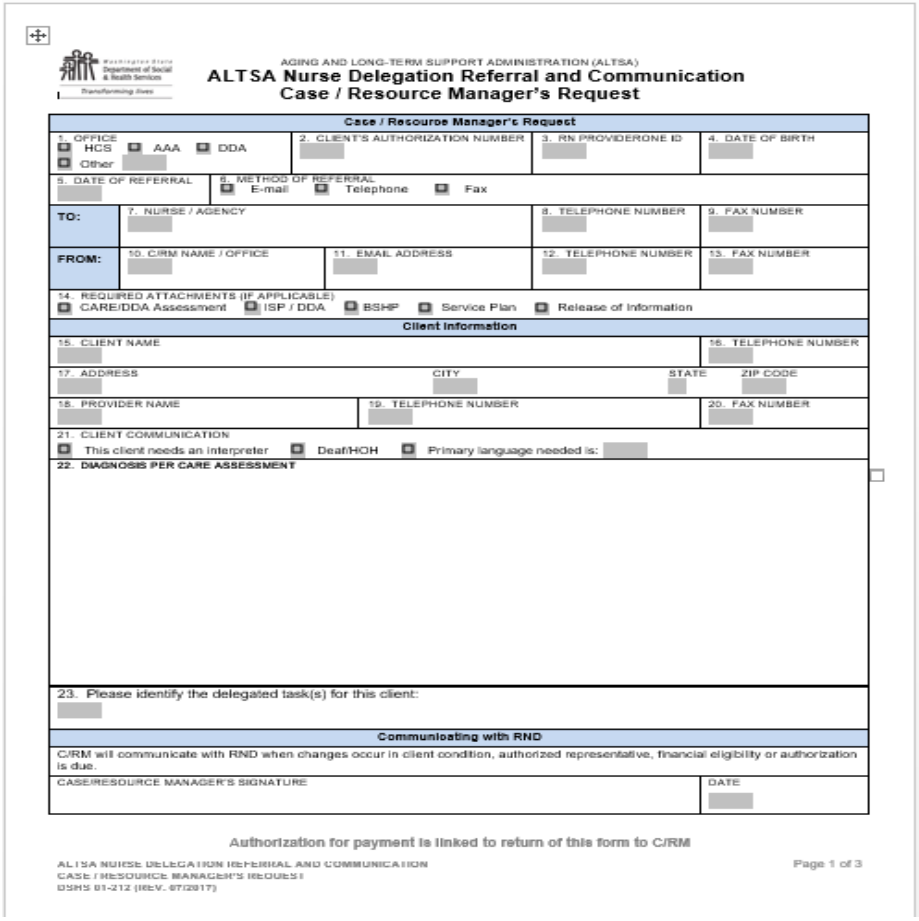
IMPORTANT: **Please be sure send secure email / fax current CARE Assessment.**

Confirmation of Receipt and Acceptance of referral by Nursing Services Provider

☐ Referral received Date Received: ☐ Additional Comments:
☐ Referral accepted
☐ Referral not accepted
☐ Nurse Assigned:
Telephone Number:

DDA NURSING SERVICE REFERRAL
DSHS 13-911 (REV. 07/2017)

REFERRAL FORM - NURSE DELEGATION #01-212



AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

ALTSA Nurse Delegation Referral and Communication
Case / Resource Manager's Request

Case / Resource Manager's Request

1. OFFICE ☐ HCS ☐ AAA ☐ DDA ☐ Other	2. CLIENT'S AUTHORIZATION NUMBER	3. RN PROVIDERONE ID	4. DATE OF BIRTH
5. DATE OF REFERRAL	6. METHOD OF REFERRAL ☐ E-mail ☐ Telephone ☐ Fax		
TO:	7. NURSE / AGENCY	8. TELEPHONE NUMBER	9. FAX NUMBER
FROM:	10. C/RM NAME / OFFICE	11. EMAIL ADDRESS	12. TELEPHONE NUMBER / 13. FAX NUMBER

14. REQUIRED ATTACHMENTS (IF APPLICABLE)
☐ CARE/DDA Assessment ☐ ISP / DDA ☐ BSHP ☐ Service Plan ☐ Release of Information

Client Information

15. CLIENT NAME			16. TELEPHONE NUMBER
17. ADDRESS	CITY	STATE	ZIP CODE
18. PROVIDER NAME	19. TELEPHONE NUMBER		20. FAX NUMBER

21. CLIENT COMMUNICATION
☐ This client needs an interpreter ☐ Deaf/HOH ☐ Primary language needed is:

22. DIAGNOSIS PER CARE ASSESSMENT

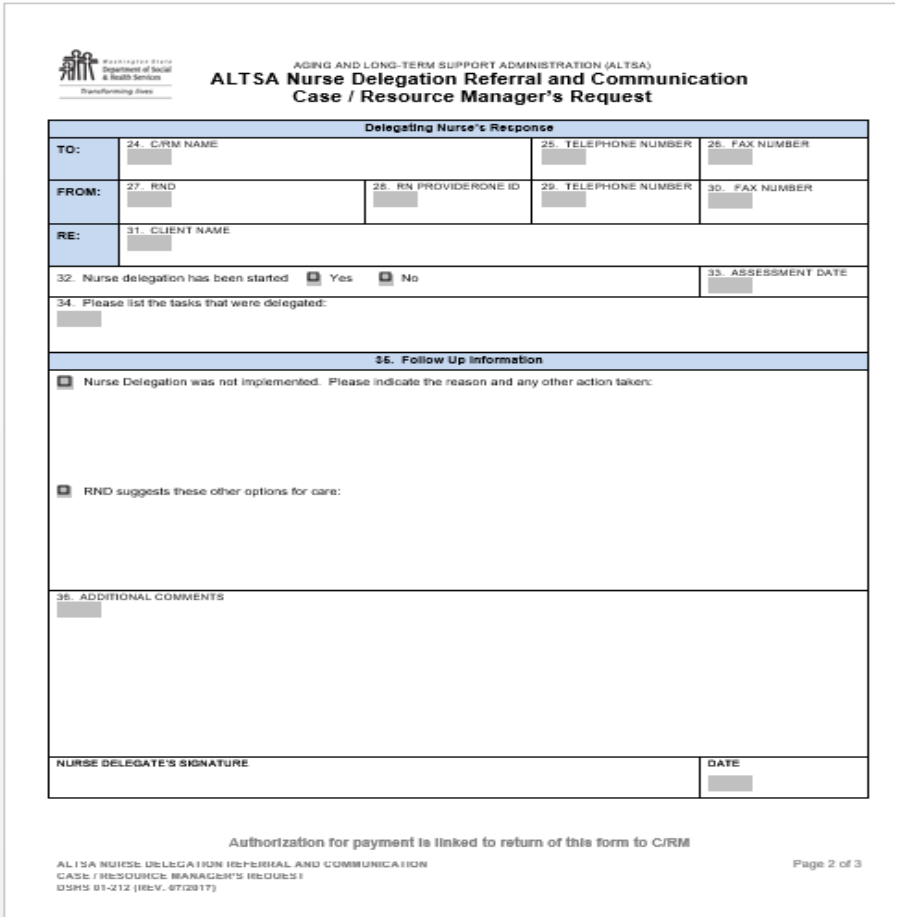
23. Please identify the delegated task(s) for this client:

Communicating with RND

C/RM will communicate with RND when changes occur in client condition, authorized representative, financial eligibility or authorization is due.

CASE/RESOURCE MANAGER'S SIGNATURE | DATE

Authorization for payment is linked to return of this form to C/RM



AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

ALTSA Nurse Delegation Referral and Communication
Case / Resource Manager's Request

Delegating Nurse's Response

TO:	24. C/RM NAME		25. TELEPHONE NUMBER	26. FAX NUMBER
FROM:	27. RND	28. RN PROVIDERONE ID	29. TELEPHONE NUMBER	30. FAX NUMBER
RE:	31. CLIENT NAME			

32. Nurse delegation has been started ☐ Yes ☐ No | 33. ASSESSMENT DATE

34. Please list the tasks that were delegated:

35. Follow Up Information

☐ Nurse Delegation was not implemented. Please indicate the reason and any other action taken:

☐ RND suggests these other options for care:

36. ADDITIONAL COMMENTS

NURSE DELEGATE'S SIGNATURE | DATE

Authorization for payment is linked to return of this form to C/RM

BASIC SKIN ASSESSMENT FORM # 13-780

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Nursing Services Basic Skin Assessment (Integumentary System – Skin, Hair, Nail)

DATE OF SERVICE | CM / RN NAME | REFERRING RN NAME

CLIENT NAME | DATE OF BIRTH | CLIENT ACES ID | CLIENT PROVIDER ONE ID

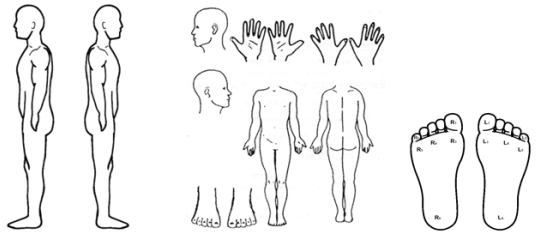
REQUEST RELATED TO (**REQUESTOR COMPLETES**): CHECK ALL THAT APPLY

- ☐ Skin Observation
- ☐ Other referral type (describe):

Documentation to be sent back to: By: ☐ Fax ☐ Email ☐ Hard Copy

Injuries Assessment Section

Beginning with any pressure injuries, number all integumentary issues consecutively, starting with #1, #2, #3, etc. (Skin, Hair and Nails)



Skin Issues

Specify all types below as numbered / designated above: The number, skin issue type and comments.

Examples of possible types of skin issues from CARE include pressure injuries, abrasions, acne / persistent redness, boils, bruises, burns, canker sore, diabetic ulcer, dry skin, hives, open lesions, rashes, skin desensitized to pain / pressure, skin folds / perineal rash, skin growths / moles, stasis ulcers, sun sensitivity, and surgical wounds. Please note there are many other skin issues not mentioned here such as irregular skin area such as boggy or mushy skin area, discoloration area(s).

Please note: Any current pressure injuries require further detailed documentation on Pressure Ulcer Assessment and Documentation, form DSHS 13-783.

NUMBER	SKIN ISSUE TYPE AND LOCATION	COMMENTS (PROVIDE FURTHER (NON-PRESSURE INJURY) DOCUMENTATION IN ADDITIONAL NOTES SECTION. FURTHER PRESSURE INJURY DOCUMENTATION REQUIRES FORM DSHS 13-783.)

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Nursing Services Basic Skin Assessment (Integumentary System – Skin, Hair, Nail)

DATE OF SERVICE | CM / RN NAME | REFERRING RN NAME

CLIENT NAME | DATE OF BIRTH | CLIENT ACES ID | CLIENT PROVIDER ONE ID

Basic Skin Assessment – Additional Detail (Check – Off and Notes)

CONSIDER HISTORY OF SKIN CONDITION

- How long has the condition been present?
- How often does it occur or recur?
- Are there any seasonal variations?
- Is there a family history of skin disease?
- Any habits, behaviors or hobbies or other affecting the skin?
- What medication is client taking?
- Any known allergies?
- Include previous and present treatments and their effectiveness.

Color: ☐ Pale ☐ WNL ☐ Cyanotic ☐ Jaundice ☐ Other (describe):
Notes:

Temperature: ☐ Afebrile ☐ Warmer than normal (febrile) ☐ Other (describe):
Notes:

Turgor: ☐ Normal ☐ Slow (tenting)
Notes:

Any foul odor: ☐ Yes ☐ No
Notes:

Moisture: ☐ WNL ☐ Dry ☐ Diaphoretic ☐ Other (describe):
Notes:

Skin integrity: ☐ WNL / intact ☐ See problem list
Notes:

Moles: ☐ Present
a. Asymmetry ☐ Yes ☐ No
b. Border ☐ Regular ☐ Irregular
c. Color
d. Diameter
Notes: Referral and follow-up for suspect / abnormal or irregular mole:

Hair: ☐ Even distributed ☐ Hair loss ☐ Other (describe):
Notes:

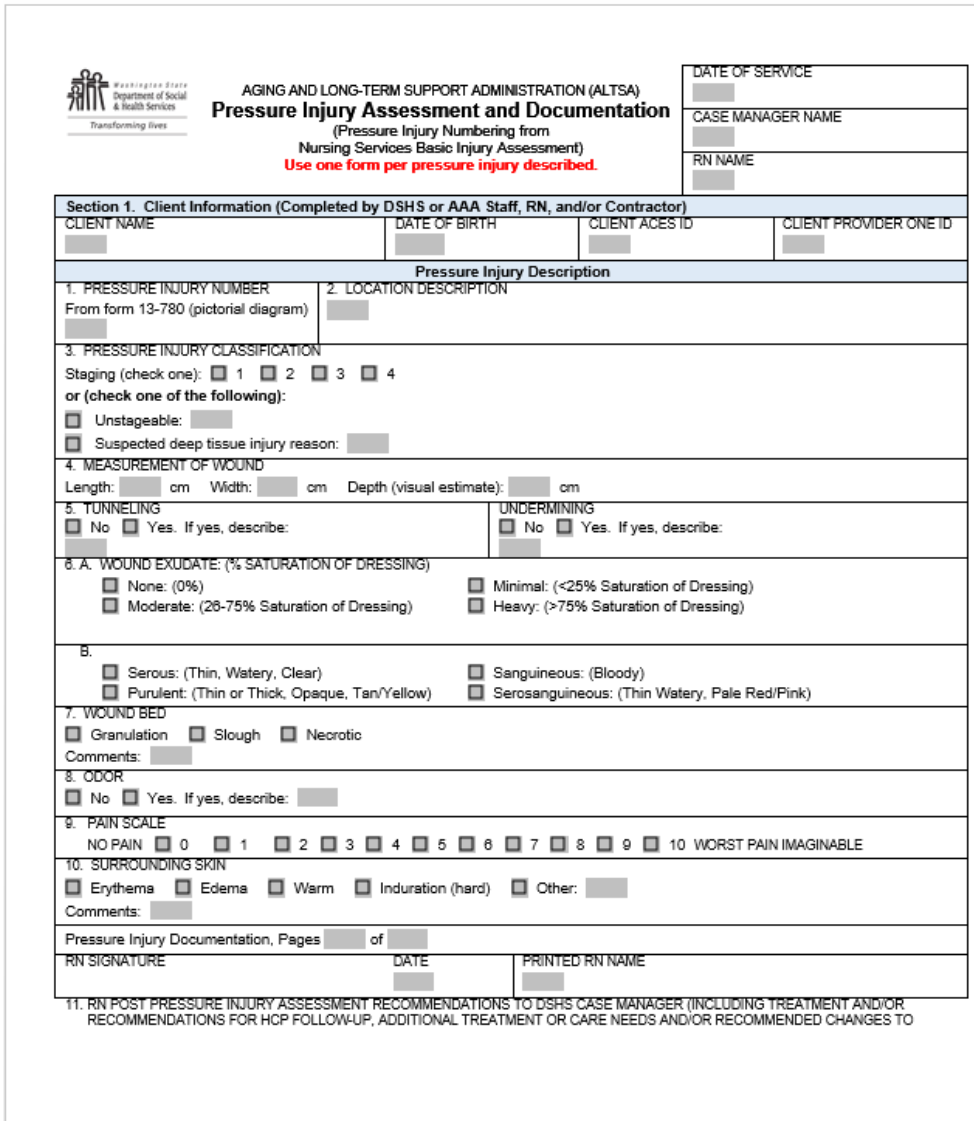
Nails: ☐ WNL ☐ Thickened ☐ Clubbing ☐ Discolored ☐ Other (describe):
Cap Refill: ☐ < 3 sec ☐ > 3 sec
Notes:

Non-injury recommendations to CM / CRM (for follow-up with HCP, treatment, care planning, or other directions):

RN SIGNATURE | DATE | PRINTED RN NAME

☐ **Additional forms / documentation attached**

PRESSURE INJURY FORM # 13-783



AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Pressure Injury Assessment and Documentation

(Pressure Injury Numbering from Nursing Services Basic Injury Assessment)

Use one form per pressure injury described.

DATE OF SERVICE

CASE MANAGER NAME

RN NAME

Section 1. Client Information (Completed by DSHS or AAA Staff, RN, and/or Contractor)

CLIENT NAME | DATE OF BIRTH | CLIENT ACES ID | CLIENT PROVIDER ONE ID

Pressure Injury Description

1. PRESSURE INJURY NUMBER
From form 13-780 (pictorial diagram)

2. LOCATION DESCRIPTION

3. PRESSURE INJURY CLASSIFICATION
Staging (check one): ☐ 1 ☐ 2 ☐ 3 ☐ 4
or (check one of the following):
☐ Unstageable:
☐ Suspected deep tissue injury reason:

4. MEASUREMENT OF WOUND
Length: cm Width: cm Depth (visual estimate): cm

5. TUNNELING
☐ No ☐ Yes. If yes, describe:

UNDERMINING
☐ No ☐ Yes. If yes, describe:

6. A. WOUND EXUDATE: (% SATURATION OF DRESSING)
☐ None: (0%)
☐ Minimal: (<25% Saturation of Dressing)
☐ Moderate: (26-75% Saturation of Dressing)
☐ Heavy: (>75% Saturation of Dressing)

B.
☐ Serous: (Thin, Watery, Clear)
☐ Sanguineous: (Bloody)
☐ Purulent: (Thin or Thick, Opaque, Tan/Yellow)
☐ Serosanguineous: (Thin Watery, Pale Red/Pink)

7. WOUND BED
☐ Granulation ☐ Slough ☐ Necrotic
Comments:

8. ODOR
☐ No ☐ Yes. If yes, describe:

9. PAIN SCALE
NO PAIN ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 WORST PAIN IMAGINABLE

10. SURROUNDING SKIN
☐ Erythema ☐ Edema ☐ Warm ☐ Induration (hard) ☐ Other:
Comments:

Pressure Injury Documentation, Pages of

RN SIGNATURE | DATE | PRINTED RN NAME

11. RN POST PRESSURE INJURY ASSESSMENT RECOMMENDATIONS TO DSHS CASE MANAGER (INCLUDING TREATMENT AND/OR RECOMMENDATIONS FOR HCP FOLLOW-UP, ADDITIONAL TREATMENT OR CARE NEEDS AND/OR RECOMMENDED CHANGES TO

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